UnitedHealth Rx™

Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage

Please fill in all information requested. ***Please print.***	Employer Use Only
Employer Name	
	Employer Verification

☐ **I do not want to enroll in the UnitedHealth Rx for Groups prescription drug plan.**

1. Personal Information - As it appears on your Medicare card

	Last Name	First Name	MI	Sex	Social Security #	Telephone #
SELF (Retiree)						( )
Permanent Home Address (No P.O. Boxes)	(Include City, State, ZIP)					
Mailing Address	(If different than above)					
Email Address	*Please email me plan information and updates:*					
Medicare Information	If you have Medicare, what is your Medicare Claim Number:				Part A Effective Date: _____/_____/_____ Part B Effective Date: _____/_____/_____	

2. ATTENTION - Please sign and date.

My signature below warrants that I have read and understand that by signing this Opt-Out Form I elect not to participate in UnitedHealth Rx for Groups prescription drug plan and that the information provided by me is accurate and complete.

Effective Date	
Retiree's Signature	Date
Signature of Individual who assisted in completing this form and relationship to applicant	Date

☐ If Durable Power of Attorney, indicate here and attach certificate or other written proof of legal guardianship.